Department of Workforce Development
Worker's Compensation Division
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REASONABLENESS OF FEE
DISPUTE RESOLUTION REQUEST

Direct all inquiries to: Medical Cost Dispute Unit and mail to the address above or telephone (608) 264-6819.

Please read the following information carefully before filling out this form.

1. This form should be used ONLY for fee disputes related to treatment provided on or after July 1, 1992.
2. Once a health care provider has been notified that the fee for treatment is in dispute, the provider may not collect or bring an action for collection of the disputed fee against the person who received the treatment, (102.16(2)(b), Stats.).
3. Generally, in denying payment, the insurer or self-insurer will use a database certified by the Department of Workforce Development to determine the "formula amount". The formula amount is the arithmetic mean of all fees in the database, plus 1.4 standard deviations from the mean, in a particular region of the state, for a specific CPT code. If the fee is less than the formula amount shown in the certified database for that procedure, the fee is presumed to be reasonable. If the fee is more than the formula amount, the insurer or self-insurer must pay only for the formula amount unless the provider demonstrates that the service provided in this case was more difficult or more complicated to provide than in the usual case.
4. In denying payment, the insurer or self-insurer must also specify, among other things:
   A. The CPT code (or other code from a certified data base) in dispute;
   B. The formula amount for the coded procedure and the certified data base from which that formula amount was obtained;
   C. The steps a provider must take prior to submitting this dispute to the department.

Personal information you provide may be used for secondary purposes [(Privacy Law, s. 15.04(1)(m)].

SECTION 1. DATES OF CORRESPONDENCE PRIOR TO SUBMITTING DISPUTE	
Please provide the dates requested in paragraphs A & B in the column at right.	**DATE**
A. Date Health care provider first billed insurer or self-insurer. NOTE: The provider has 6 months to file a dispute resolution request with the department from the date the insurer or self-insurer first refuses to pay the bill.	
B. Date insurer or self-insurer first refused to pay the fee. NOTE: If this date is not within 30 days of the billing date shown in Section 1A, the insurer shall compute and pay interest from this date if the provider prevails.	

SECTION 2. ISSUES IN DISPUTE	**YES**	**NO**
A. In refusing to pay the disputed fees (listed in Section 4), did the insurer state it was using a data base certified by the department?		
B. Did the insurer state that the disputed fees are higher than the formula amount in a certified data base?		
C. Is the provider alleging that a fee greater than the formula amount from a certified data base is justified because the service for each disputed fee was more difficult or complicated to provide than the usual care?		
D. If the answer to C is yes, and at least 20 days prior to filing this dispute, did the provider explain to the insurer the reason why the higher fee was justified?		
E. If the answer to D is yes, did the insurer respond to the explanation?		
F. Is there a dispute about whether the fee for service was properly coded?		
G. Are there other matters in dispute? (If yes, attach a narrative explanation.)		
H. Are you continuing to treat this patient for the injury?		

PLEASE CONTINUE TO PROVIDE INFORMATION ON THE REVERSE SIDE

SECTION 3.	NAME	ADDRESS	SECTION 5. As required by law, I am enclosing copies of all correspondence and medical records relating to this dispute including: 1. The insurer's or self-insurer's initial notice refusing to pay. ☐ Yes ☐ No 2. My written response explaining to the insurer why the fee was justified. ☐ Yes ☐ No As required by law, I am sending one copy of this dispute resolution request with all attachments to the insurer or self-insurer at the same time I filed this request with the Division. ☐ Yes ☐ No
Health Care Provider			
Insurer or Self-Insurer			
Employer (at time of injury)			
Employee - Patient ---------- Injury Date ---------- Social Security No.	---------- ---------- _____ - _____ - _____	Your social security number is mandatory under Wisconsin Statutes and will be used to identify the claimant. Failure to comply may result in penalties or delayed payment of benefits.	The health care provider whose fee is the subject of this dispute: Name: _____ Lic. No. to Practice in WI: _____ Signature: _____ Date Signed: _____
Certified Data Base Used by Insurer			

The provider's fee is based upon the zip code where the service was provided. If the zip code indicated for the health care provider in section 3 of this form is not the zip code location where the service was provided, please indicate the correct zip code for each service listed in section 4.

SECTION 4.

SPECIFIC TREATMENT IN DISPUTE	TREATMENT ZIP CODE	NUMBER OF TREATMENTS	NUMBER OF UNITS	CPT BILLING CODE	CPT MODIFIER	DATES FROM	DATES TO	AMOUNT CHARGED	AMOUNT PAID	AMOUNT DISPUTED
							TOTALS			